For official use only:
NST ID _____ CDC ID _____

(Part I. Form to be completed by CDPH.)

PART II. Acute Neurologic Illness with Limb Weakness: Patient Summary Form

Part II. Form to be completed by, or in conjunction with, a physician who provided care to the patient during the neurologic illness.
Once completed, submit to California Department of Public Health via secure fax: 916-440-5940 or email: NeuroSurveillance@cdph.ca.gov.

1.Today's date__ __/__ __/__ __ __ __ *(mm/dd/yyyy)* **2**.Name of person completing form: _____

3. Affiliation_____Phone: _____Email: _____

Fax (for sending results): _____ Alternate Fax: _____

4. Name of physician who can provide additional clinical/lab information, if needed _____

5. Affiliation_____ Phone: _____ Email: _____

6. Name of main hospital that provided patient's care:_____ **7**.State: _____ **8**.County: _____

9. MR#: _____**10**. Patient Name: _____**11**. Patient's sex: ☐ M ☐F **12**. Patient's DOB: __ __/__ __/__ __ __ __

Patient's age: _____years AND _____months Patient's residence: **13**. State_____ **14.** County_____

15. Race: ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐American Indian or Alaska Native ☐White *(check all that apply)* **16**. Ethnicity: ☐Hispanic ☐Non-Hispanic

17. Date of onset of limb weakness: __ __/__ __/__ __ __ __ *(mm/dd/yyyy)* **18**. Was patient admitted to a hospital? ☐yes ☐no ☐unknown

19. Date of admission to **first** hospital__ __/__ __/__ __ __ __ **20.**Date of discharge from **last** hospital__ __/__ __/__ __ __ __(or ☐ still hospitalized)

21. Current clinical status: ☐recovered ☐not recovered, but improved ☐not improved ☐Deceased: **22**.Date of death__ __/__ __/__ __ __

Signs/symptoms/condition at ANY time during the illness:												
	Right Arm			Left Arm			Right Leg			Left Leg		
23. Since neurologic illness onset, which limbs have been acutely weak? [*indicate yes(y), no (n), unknown (u)* ***for each limb***]	Y	N	U	Y	N	U	Y	N	U	Y	N	U
24. Date of neurologic exam (recorded at worst weakness thus far) *(mm/dd/yyyy)*	__ __/__ __/__ __ __ __											
25. Reflexes in the **affected** limb(s): (recorded at worst weakness thus far)	☐ Areflexic/hyporeflexic (0-1) ☐ Normal (2) ☐ Hyperreflexic (3-4+)											
26. Any sensory loss/numbness in the **affected** limb(s), at any time during the illness? (paresthesias should not be considered here)	Y N U											
27. Any pain or burning in the **affected** limb(s)? (at any time during illness)	Y	N	U	Y	N	U	Y	N	U	Y	N	U

	Yes	No	Unknown
28. Sensory level on the torso (ie, reduced sensation below a certain level of the torso)? (at any time during illness)			
29. At any time during the illness, please check if the patient had any of the following cranial nerve signs:			
☐Diplopia/double vision (If yes, circle the cranial nerve involved if known: 3 / 4 / 6)			
☐Loss of sensation in face ☐ Facial droop ☐Hearing loss ☐ Dysphagia ☐ Dysarthria			
30. Any pain or burning in neck or back? (at any time during illness)			
31. Bowel or bladder incontinence? (at any time during illness)			
32 .Cardiovascular instability (e.g, labile blood pressure, alternating tachy/bradycardia)? (at any time during illness)			
33. Change in mental status (e.g, confused, disoriented, encephalopathic)? (at any time during illness)			
If yes, specify:			
34. Seizure(s)? (at any time during illness)			
35. Received care in ICU because of neurologic condition? (at any time during illness)			
If yes, admission date: __ __/__ __/__ __ __ __			
36. Received invasive ventilatory support (e.g, intubation, tracheostomy) because of neurologic condition?			
If yes, start date: __ __/__ __/__ __ __ __ If yes, specify type of ventilator support:			

Please check if patient had any of the following symptoms:

Rash	Y	N	U	Coma	Y	N	U
Headache	Y	N	U	Autonomic instability	Y	N	U
Stiff neck	Y	N	U	Movement disorder	Y	N	U
Ataxia	Y	N	U	Hypersalivation	Y	N	U

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Other patient information:

Within the 4-week period **BEFORE onset** of **limb weakness**, did patient:	Yes	No	Unk	
37. Have a respiratory illness?				**38**. If yes, date of onset __ __/__ __/__ __ __ __
Have gastrointestinal illness?				If yes, date of onset __ __/__ __/__ __ __ __
39. Have a fever, measured by parent or provider and ≥ 38.0°C/100.4°F?				**40**. If yes, date of onset __ __/__ __/__ __ __ __
41. Receive oral, IM or IV steroids?				
42. Receive any other systemic Immunosuppressant(s)?				**43.** If yes, list:
44. Travel outside the US?				**45.** If yes, list country:
Travel outside of state or jurisdiction?				If yes, list locations:
46. Does patient have any underlying illnesses?				**47.** If yes, list
48. On the **day of onset of limb weakness**, did patient have a fever? (see definition above)				

Polio vaccination history:	
Are immunizations up to date? ☐yes ☐no ☐unknown	
49. How many doses of **inactivated polio vaccine (IPV**) are **documented** to have been received by the patient before the onset of weakness?	_____doses ☐unknown
50. How many doses of **oral polio vaccine (OPV)** are **documented** to have been received by the patient before the onset of weakness?	_____doses ☐unknown
51. If you do not have documentation of the *type* of polio vaccine received: **a**.What is total number of **documented** polio vaccine doses received before onset of weakness?	_____doses ☐unknown

Neuroradiographic findings: (*Indicate based on <u>most abnormal</u> study)*

<u>MRI of spinal cord</u> **52**. Date of study __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*
53. Levels imaged: ☐cervical ☐thoracic ☐lumbosacral ☐unknown
54. Gadolinium used? ☐yes ☐no ☐unknown

55. Location of lesions:	☐cervical cord ☐thoracic cord ☐conus ☐cauda equina ☐unknown	Levels of cord affected (if applicable): **56**. Cervical: _____ **62.** Thoracic: _____
For **cervical and thoracic cord** lesions	**57.** What areas of spinal cord were affected?	☐predominantly gray matter ☐predominantly white matter ☐both equally affected ☐unknown
	58. Was there cord edema?	☐yes ☐no ☐unknown
For **cervical, thoracic cord or conus** lesions	**59**. Did any lesions enhance with GAD?	☐yes ☐no ☐unknown
For **cauda equina** lesions	**60**. Did the **ventra**l nerve roots enhance with GAD?	☐yes ☐no ☐unknown
	61. Did the **dorsal** nerve roots enhance with GAD?	☐yes ☐no ☐unknown

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MRI of brain **62.** Date of study __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*
63. Gadolinium used? ☐ yes ☐no ☐unknown

64. Any **supratentorial** (i.e, lobe, cortical, subcortical, basal ganglia, or thalamic) lesions	☐yes ☐no ☐unknown	
	65.If yes, indicate location(s)	☐cortical ☐subcortical ☐basal ganglia ☐thalamus ☐unknown
	66. If yes, did any lesions enhance with GAD?	☐yes ☐no ☐unknown
67. Any **brainstem** lesions?	☐yes ☐no ☐unknown	
	68. If yes, indicate location:	☐midbrain ☐pons ☐medulla ☐unknown
	69. If yes, did any lesions enhance with GAD?	☐yes ☐no ☐unknown
70. Any **cranial nerve** lesions?	☐yes ☐no ☐unknown	
	71. If yes, indicate which CN(s):	CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral
		CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral
	72. If yes, did any lesions enhance with GAD?	☐yes ☐no ☐unknown
73. Any lesions affecting the **cerebellum**?	☐yes ☐no ☐unknown	

74. Was an EMG done? ☐yes ☐no ☐unknown If yes, date __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*
75. If yes, was there evidence of acute motor neuropathy, motor neuronopathy, motor nerve or anterior horn cell involvement?☐yes ☐no ☐unkn

CSF examination: **76**. Was a lumbar puncture performed? ☐yes ☐no ☐unknown If yes, complete 77 (*If more than 2 CSF examinations, list earliest and then most abnormal)*

	Date of lumbar puncture	WBC/mm3	% neutrophils	% lymphocytes	% monocytes	% eosinophils	RBC/mm3	Glucose mg/dl	Protein mg/dl
77a. CSF from LP1									
77b. CSF from LP2									

Pathogen testing performed:

78. Was **CSF** tested for the following pathogens?	Date of specimen collection __ __/__ __/__ __ __ __ ☐ Not done
	Enterovirus PCR: ☐ Positive ☐ Negative ☐ Not done If positive: type: ☐ Not typed
	West Nile Virus PCR: ☐ Positive ☐ Negative ☐ Not done If positive, test type: ☐ IgM ☐ PCR
	Herpes Simplex Virus PCR: ☐ Positive ☐ Negative ☐ Not done Positive specimen: ☐ CSF ☐ Respiratory Specimen, specify: ☐ Stool Date of specimen collection __ __/__ __/__ __ __ __
	Cytomegalovirus PCR: ☐ Positive ☐ Negative ☐ Not done
	Varicella Zoster Virus PCR: ☐ Positive ☐ Negative ☐ Not done
	Other pathogen identified: specify: Type of test:

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79. Was a **respiratory tract specimen** tested for the following pathogens?	Date of specimen collection __ __/__ __/__ __ __ __ ☐ Not done
	Enterovirus/rhinovirus PCR: ☐ Positive ☐ Negative ☐ Not done If positive: type: ☐ Not typed
	Adenovirus PCR: ☐ Positive ☐ Negative ☐ Not done If positive: type: ☐ Not typed
	Influenza virus PCR: ☐ Positive ☐ Negative ☐ Not done If positive: type: ☐ Not typed
	Other pathogen identified: specify: Type of test:

80. Was a **stool specimen** tested for the following pathogens?	Date of specimen collection __ __/__ __/__ __ __ __ ☐ Not done
	Enterovirus PCR: ☐ Positive ☐ Negative ☐ Not done If positive: type: ☐ Not typed
	Poliovirus PCR: ☐ Positive ☐ Negative ☐ Not done
	Poliovirus culture: ☐ Positive ☐ Negative ☐ Not done
	Other pathogen identified: specify: Type of test:

81. Was **serum** tested for the following pathogens?	Date of specimen collection __ __/__ __/__ __ __ __ ☐ Not done
	West Nile Virus: ☐ Positive ☐ Negative ☐ Not done If positive, test type: ☐ IgM ☐ PCR
	Other pathogen identified: specify: Type of test:

82. Describe any other laboratory finding(s) considered to be significant_____

_____

83. Was/Is a **specific etiology** considered to be the most likely cause for the patient's neurologic illness? ☐yes ☐no ☐unknown

84. If yes, please list etiology and reason(s) considered most likely cause _____

_____

Treatment: 85. Were any of these therapies administered for the acute neurologic illness? (as of time of form completion)

	Yes	No	Unknown	
a. Antibiotics				If yes, date first administered: __ __/__ __/__ __
b. Antivirals				If yes, specify_____; date first administered: __ __/__ __/
c. Corticosteroids				If yes, date first administered: __ __/__ __/__ __
d. Intravenous immune globulin (IVIG)				If yes, date first administered: __ __/__ __/__ __
e. Plasma exchange or Plasmapheresis				If yes, date first administered: __ __/__ __/__ __
f. Interferon				If yes, specify_____; date first administered: __ __/__ __/
g. Other immunosuppressive therapy				If yes, specify_____; date first administered: __ __/__ __/

86. Other information you would like us to know _____

_____

_____

87. Indicate which type(s) of specimens from the patient are **currently stored**, and could be available for possible additional testing at CDC:

☐ CSF ☐ Nasal wash/aspirate ☐BAL spec ☐Tracheal aspirate ☐NP/OP swab ☐Stool ☐Serum ☐ Other, list _____

☐ No specimens stored